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Doctor-Patient Relationships: A Puzzle of Fragmented Knowledge

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Abstract

The doctor-patient relationship has been and remains a keystone of care. But, there are many ways of understanding, classifying and practicing the doctor-patient relationship. In this scenario, this article begins the task of organizing the different ways of understanding, naming, differentiating, classifying and practicing the doctor-patient relationship. It is concluded that the following concepts can be differentiated: 1) Hierarchy of complexity dimensions of the doctor-patient continuity relationship; 2) According to historical stages; 3) According to the degree of interpersonal relationship; 4) According to the control exercised by the physician or the patient; 5) According to the level of participation; 6) According to the “creators of contexts” models; 7) According to the length of interpersonal continuity; 8) According to pharmacological prescriptions; 9) According to the characteristics of medical service; 10) According to the psychosocial aspects of diseases; 11) According to age; and 12) Doctor-patient relationship with patients and special situations: emigrants, foreigners, patient with ill-defined symptoms, with the insane, with the psychotic, with the patient with visual or hearing impairment, at home, with differences of race, social class, gender, etc.). It is concluded that the doctor-patient relationship is a complex, multiple and heterogeneous concept that cannot be defined in a unique way or generalize the concept of “good” relationship, but there are “many doctor-patient relationships” appropriate according to their contexts, which also implies redefining the instruments for measuring this relationship.

Keywords: Framework; General Practice; Patient Satisfaction; Physician-Patient Communication; Physician-Patient Relations; Sanitary Attention

Introduction

The doctor-patient relationship is a complex phenomenon conformed by several aspects, among which we can highlight the doctor-patient communication, the patient's participation in the decision making and the patient's satisfaction. These characteristics have been associated with the communication behavior of the doctor and the autonomy of the patient in medical care. The transcendence of the doctor-patient relationship is given by the confirmed fact of its influence on the results of health care [1,2]. In fact, the quality of doctor-patient interaction and communication is a powerful indicator of the quality of medical care and plays a fundamental role in the medical care process [3].

Among the various benefits that have been described in the literature on the interpersonal continuity of the doctor-patient relationship can be cited, that it generates trust and improves the doctor-patient relationship; it gives clinical advantages by increasing knowledge about the patient, facilitates diagnosis and treatment; it

presents the unique opportunity to study the natural history of the disease; it allows to see how the presence of a problem in a family member can be a marker of conflict in another or other members of the same family; it facilitates the follow-up of the chronically ill; the one that facilitates the implementation of preventive elements; it favors the satisfaction with the service; it saves costs to the health system (better use of services, fewer hospitalizations, etc.) [2]; and there is evidence of better compliance, satisfaction and recovery of patient information in patient-centered consultations [4-6].

General Medicine / Family Medicine are defined in terms of relationships, rather than in terms of diseases or technology. Therefore, the doctor-patient communication is one of the most essential dynamics in health care, which affects the course of patient care and compliance by the patient with the recommendations for care [3].

However, the desirable model of doctor-patient interaction has been the subject of controversy and debate in recent years without ever reaching an adequate degree of consensus on how to define it and even name and measure it [7]. Thus, there are many ways of understanding, classifying and practicing the doctor-patient relationship, and although there is a lot of literature on this

subject, is striking is little written about to give an overview.

In this scenario, the aim of this article is to show a general, comprehensive approach, and from various points of view and perspectives of the analysis of the different ways of understanding, naming, differentiating, classifying and practicing the doctor-patient relationship.

Discussion

There are numerous categories, levels, or ways of understanding the doctor-patient relationship, each of which shows nuances or differential characteristics, among which can be cited: 1) Hierarchy of complexity dimensions of the doctor-patient continuity relationship; 2) Medical-patient relationship according to historical stages; 3) Types of doctor-patient

relationship according to the degree of interpersonal relationship; 4) According to the control exercised by the physician or the patient; 5) According to types of doctor-patient relationship according to the level of participation; 6) According to models of relationship “creators of context”; 7) Types of doctor-patient relationship in relation to the duration of interpersonal continuity; 8) Medical-patient pharmacological relationship; 9) Types of patient physician relationship according to the characteristics of the medical service; 10) According to the psychosocial aspects of diseases; 11) Doctor-patient relationship according to age; and 12) Doctor-patient relationship with patients and special situations: emigrants, foreigners, patient with ill-defined symptoms, with the insane, with the psychotic, with the patient with visual or hearing impairment, at home, with differences of race, social class, gender, etc. (Table 1, Figure 1).

| Categories, Levels, or Ways to Understand the Medical-Patient Relationship | Concepts |
|---|--|
| Hierarchy of complexity dimensions of the doctor-patient continuity relationship | Informative relationship, geographic relationship, interdisciplinary or team continuity relationship, longitudinal or chronological relationship, interpersonal relationship, and doctor-family interpersonal relationship |
| Medical-patient relationship according to historical stages | Magical, mystic, etc. |
| Types of doctor-patient relationship according to the degree of interpersonal relationship | Technical or psychotherapeutic interpersonal model |
| According to the control exercised by the physician or the patient | Paternalistic, consumerist, mutual relationship, and absent relationship |
| According to types of doctor-patient relationship according to the level of participation | “Active-passive” relationship, “Guided cooperation” relationship, and “Mutual participation” relationship |
| According to models of relationship “creators of context” | Unidirectional information strategy, Persuasive or consultative strategy, and Participatory-cooperative strategy with empowerment |
| Types of doctor-patient relationship in relation to the duration of interpersonal continuity | The young doctor emphasizes his role as a biomedical technician with a “romantic” character. The doctor with a few years in his practice approaches the concept of participation and empathy. The mature doctor usually produces an adult interpersonal relationship, centered on empathy and assertiveness. |
| Medical-patient pharmacological relationship | From the doctor as a drug in itself, to the doctor as a seller of drugs that are required by the patient |
| Types of patient physician relationship according to the characteristics of the medical service | Doctor-patient relationship in gynaecology, surgery, in dermatology, in intensive care, etc. |
| According to the psychosocial aspects of diseases | Cardiovascular patient-doctor relationship, hypertensive doctor-patient relationship, asthmatic patient, digestive patient, patient in psychiatric diseases, in digestive, endocrinological problems, with an incurable disease, with haematological diseases, with cancer, or the doctor-patient relationship with AIDS, among others |
| Doctor-patient relationship according to age | Children, young people, adults, the elderly |
| Doctor-patient relationship with patients and special situations | Emigrants, foreigners, patient with ill-defined symptoms, with the insane, with the psychotic, with the patient with visual or hearing impairment, at home, with differences of race, social class, gender, etc. |

Table 1: Categories, Levels, or Ways to Understand the Medical-Patient Relationship.

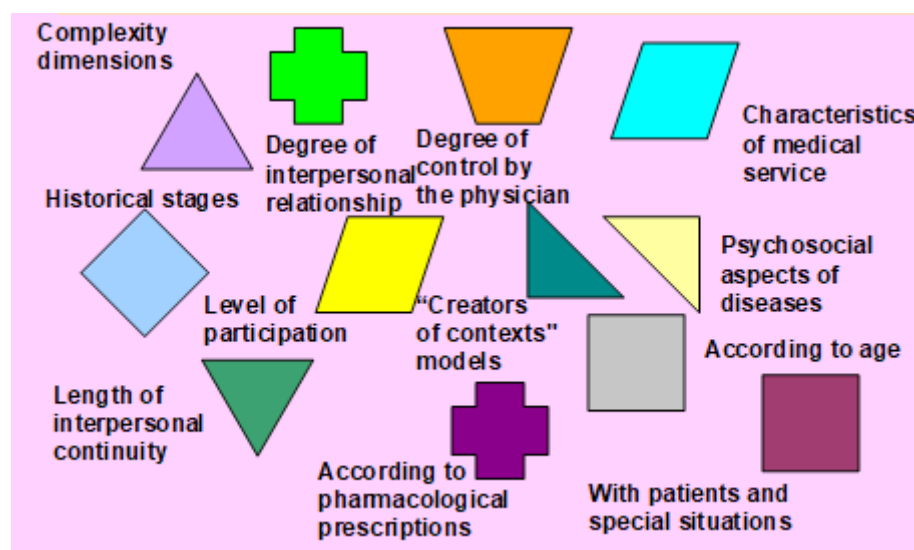


Figure 1: The Puzzle of Categories, Levels, or Ways to Understand the Doctor-Patient Relationship.

These categories are frequently types and forms that overlap and have translations from one system or classification model to another. In addition, there may be models that are not included here. But it is intended to start the construction of the puzzle of the different doctor-patient relationships, trying to show an integrating vision.

Dimensions of Complexity of the Doctor-Patient Continuity Relationship

There seems to be a hierarchy of dimensions from less to more complexity of the doctor-patient continuity relationship, where successively the more complex dimensions include the concepts of the previous ones [4]. These dimensions can be described as:

A) Informative relationship: It is the availability of clinical information to any healthcare provider that treats the patient; B) Geographical relationship: Refers to the care provided with continuity, regardless of the location of the patient; C) Interdisciplinary continuity relationship or as a team. It implies the care that allows the patient's prior knowledge even when it requires a wide range of specialized services. The doctor-patient relationship is extended to a new type of relationship that links several physicians who treat the same patient in collaboration [8]; D) Longitudinal or chronological relationship: It refers to the fact that health care occurs in the same place, with the same medical record, and with the same professionals, so that there is a growing knowledge of the patient; E. Interpersonal relationship doctor-patient: Refers to a special type of longitudinal continuity in which there is a continuous personal relationship between the patient and care, and is characterized by trust and personal responsibility. Attachment theory can provide an explanation for the need of patients to see a regular GP [9]; F) Interpersonal relationship doctor-family: Refers to a system of care in which all members of the family receive assistance from the same family doctor,

who thus has knowledge of the health problems of other family members [10-12].

The Doctor-Patient Relationship According to Historical Stages

The doctor-patient relationship has historically passed through different stages such as accompaniment, magical, mystical, clerical, professional, technical and integral [13]. In the last decades of the twentieth century, the way in which doctors and patients related to each other changed more than in the previous twenty centuries. The change from a paternalistic model to an autonomous model represented a transformation with few historical precedents. Before the last two decades, the relationship was predominantly between a patient seeking help and a doctor who made the decisions that were to be silently fulfilled by the patient. In this paternalistic model of the doctor-patient relationship, the doctor uses his skills to choose the necessary interventions and the most likely treatments to restore the patient's health or improve their pain. Any information provided to the patient is selected to encourage them to give their consent to the doctor's decisions. This description of asymmetric or unbalanced interaction between the doctor and the patient has been questioned in the last 20 years. In response to this model, a more active and patient-centered role has been proposed in which there is greater control of the patient, a reduction in the doctor's domain and greater mutual participation, and has now become the predominant model in the clinical practice [14,15].

In recent years, more changes are still taking place that modify the tendencies of the doctor-patient relationship: social and political changes, local culture, advances in medical practice, as well as the consumerist emphasis, and the institutional environments, which are giving rise to greater diversity in relationship models [16].

Types of Doctor-Patient Relationship According to Degree of Interpersonal Relationship

Two types of relationships can be distinguished according to whether the interaction between the doctor and the patient is directly interpersonal or mediated by the diseased organ: A) A technical model, which is intended to be a repair service. It focuses on the organ “that does not work well” and the patient acquires connotations of the client who requests the repair of the same. It is a more pragmatic, operational and functional relationship; B) An interpersonal relationship that is used in psychiatry, psychotherapy, and general medicine. The doctor not only sees the diseased organ, but the whole patient, the somatic and the psychic. The attitude of the therapist resonates with that of the patient, so that “it goes from a person’s medicine to the medicine of two people.” No doubt both models complement each other [17-20].

Types of Doctor-Patient Relationship According to the Control Exercised by the Physician or the Patient

The following models can be differentiated: A) “Paternalistic” relationship: When the doctor dominates the relationship by making the decisions that are most convenient for the patient cooperates with the physician, that is, to do what is commanded. It works best with patients of lesser education and who willingly accept authority; B) “Consumerist” relationship model: In contrast, younger, more educated and more sceptical patients tend to be more demanding. They exercise more control than the doctor and give the impression that they “consume” health services when they are in front of the professional; C) “Mutual” relationship: there is co-participation. The control and power in the relationship are balanced between doctors and patients; D) “Absent” relationship: Finally, sometimes patients or physicians do not exercise sufficient control, so the relationship is considered be “absent” and patients may drop out of treatment thinking that they have not been given proper attention or that the doctor is incompetent or insensitive [21,22].

Types of Doctor-Patient Relationship According to Participation Level

Several types of doctor-patient relationship have been described that are frequently used with the patient, according to their level of participation: A. A type of relationship is the “active-passive”: the patient, by his pathology, participates very little in the relationship. The doctor behaves with the patient as a father would with his son who is a few months old. It may be adequate in the acute stages, especially if there is some degree of diminution of consciousness; B. “Guided cooperation”: the patient can receive guidance and cooperate in their treatment. The doctor behaves like a father in front of a teenage son. It pursues ties that guarantee the realization of the appropriate treatment. It may be adequate after the days of acute picture; C. Finally, in the chronic phase, a relationship of “mutual participation” may be appropriate. The doctor should discuss with the patient his management of the disease and of the situations that create anxiety [18,23-26].

This relationship of mutual participation has also been

called “patient-centered” [27], and is characterized by trying to provide ways to understand “the sick experience”, considering it a fundamental part in order to reach a diagnosis and adequate treatment. It is admitted that patient-centered care improves outcomes and costs. Physicians who get their patients involved in managing their own health care have better outcomes and order fewer unnecessary tests and referrals. Likewise, evidence has been found of improving compliance, satisfaction and recall of the doctor’s information in patient-centered consultations [28,29]. Patient-centered care is consistent with the biopsychosocial model [30]. This model incorporates thoughts, beliefs, behaviors, and the social context and the interactions with biological processes, to better understand and manage disease and disability. In this model the biological, psychological and social processes are integrated and inseparable.

Models of Relationship “Creators of Context”

The continuity of relationships between the doctor and patient, even in a tacit way, creates a certain context through the relationships and communications established with patients or clients of the consultation. Thus, the “creation of context” is the result of implementing a series of strategies of doctor-patient relationship to make services acceptable, relevant and accessible [31]. Optimal healing environments are defined as medical care contexts that are based on mutual respect and create positive and resilient relationships among participants, using the qualities and resources of those relationships to improve health. Understanding optimal healing environments also requires an understanding of how doctors and patients share time and space together in the consultation [32]. There would be different models of doctor-patient relationship “creators of context”: A) a unidirectional information strategy: the relationship between professional and patient or client is “dissociated”. The needs may be different and are not taken into account. The relationships are centered on the professional and what he believes should be done. It is decontextualized; B) a persuasive or consultative strategy: the relationship between professional and patient or client is “convergent”; shows interest or concern for the other, or adjusts to the other; C) a significant strategy-participative-cooperative-trainer: the relationship between professional and patient or client is “share” and “help”.

These models of “creation and context” correspond to the educational models and to the types of participation: A) informative; B) persuasive or motivating; and C) participative, contextualized and favoring of empowerment.

Types of Doctor-Patient Relationship According to the Duration of Interpersonal Continuity

The young doctor with a few months in his practice emphasizes his role as a biomedical and team technician, with a “romantic” character - “he will cure everything” [4]. It is a virtuous model or doctor-hero with a paternalistic or “active-passive” relationship. The doctor with a few years in his practice is aware that only with biomedical intervention cannot address and solve the problems presented by patients; it approaches the concept of participation and empathy, and a democratic relationship of “guided

cooperation” usually predominates. The mature doctor with many years of continuity in his practice sees that not all patients want to participate, and some are demanding or impolite; they only want to achieve their interests without thinking. There is a rethinking of the terms of the doctor-patient moral contract: an adult interpersonal relationship, centered on empathy and assertiveness.

On the other hand, the type of doctor-patient relationship does not always remain stable in a certain model, but there are “moments” of that relationship according to the types of health problems, the evolutionary moments of the disease episode, the mechanisms of transfer and countertransference (emotions arising from the doctor to the patient and vice versa) and these “moments of relationship” are conditioned by the social class to which doctor and patient belong, gender, race, age, ideology and mechanisms of social control, etc.

Doctor-Patient Relationship in Pharmacological Prescriptions

It is important to know that the presence of the pharmacological prescription modifies the doctor-patient relationship. Classically, it is considered that the drug most used in general practice is the doctor himself. The interview itself is therapeutic. This medicine called “doctor” is powerful and can have many side effects. You have to know how to dose it and prescribe it. However, pharmacological prescription tends to modify this situation, and it goes to occupy itself the center of the relationship: it becomes a relationship of doctor and patient with the drug, both in prescriptions of a single time nature and repeated in chronic processes [33-36].

Types of Patient Physician Relationship According to the Characteristics of the Medical Service

The doctor-patient relationship has different nuances in the different medical specialties. So, it can be mentioned as examples:

-In general medicine / family medicine [37] where the GP’s task “is not to diagnose diseases but to understand people and contexts”, is especially important. In this sense, a series of differential characteristics of communication and relationship has been described, such as: it is unstructured (diagnosis and treatment occur simultaneously and integrated), strategic, taking advantage of opportunities, contextualized, focusing on emotions, pragmatic, it is built in each interview, that enriching spirally the previous ones, etc.

-In gynaecology and obstetrics [17] there is a great awareness of the great importance of achieving adequate professional relationships with women during their confrontation with such important experiences as pregnancy, childbirth and the puerperium. There may be alterations in the affective state of the pregnant woman, where irritability may occur. Therefore, it is especially important that the relationship includes understanding, empathy and willingness to help, as well as transmitting security, optimism, affection and availability to the helping relationship. Another important aspect here is that of tactile communication, performing the exploratory manoeuvres with the greatest kindness, as this increases the safety of the pregnant woman when she appreciates

the concern of her doctor to avoid causing any discomfort during her attention.

-In intensive therapy [38], where relationships are established not only with the patient, but also with the relatives; here, gestures, voice modulation, facial expressions or even silence are very important.

-In dentistry [39] where the dentist and the patient alternate in the treatment and responsibility of the patient’s mouth and teeth, and there is a great influence of psychosocial problems in dental practice.

-In oncology [40] where it is especially important to provide information according to the patient’s profile, telling the truth and relying on the patient’s family.

-Or in dermatology [41], in nephrology, psychiatry, etc., they are all levels of attention that involve differential aspects of the doctor-patient relationship.

According to the Psychosocial Aspects of Diseases

Illness is a system of interpretation. The patient’s experience is opened during the clinical consultation. The disease has symbolic and socio-cultural meanings for the patient and the doctor. The patient’s response to the psychological stress that evokes the medical illness and the extension of the regression that occurs as a consequence of the diseases modify the quality of the doctor-patient relationship). So, the doctor-patient relationship can be different, for example, in the cardiovascular patient, the hypertensive patient, the asthmatic patient, the digestive patient, patient with psychiatric diseases, in endocrinological problems, with an incurable disease, with haematological diseases, with cancer, or with AIDS, among others [42,43].

In this way, some examples would be: A. Relationship doctor-cardiovascular patient (The relationship with a patient with the imminence of death anxiety, also generates distress to the doctor, and requires a control of verbal and non-verbal manifestations to transmit security); B. Relationship doctor-patient with arterial hypertension (the relationship can focus on the persuasion that seeks to guarantee therapeutic compliance); C. Relationship doctor-asthmatic patient (there are important psychosocial factors that advise a relationship of “mutual participation” where to explore, ventilate and help the patient about their conflicts); C. Relationship doctor-digestive patient (The great importance of psychosocial factors in these pathologies, usually produce feelings of dependence) [18]; D. Relationship doctor-patient with psychiatric diseases, where It makes it necessary to fine-tune sensitivity and maximize quiet listening skills [44]. (Frequently, the relationship with these patients is feared and rejected. There is the need to address emotions, feelings, and personal and socio-family situations that are critical, which often accompanied by very different somatic symptoms).

Doctor-Patient Relationship According to Age

The communication process can be further complicated by

age. Older patients are actually more heterogeneous than younger people. In addition, the normal aging process may involve sensory loss, decreased memory, slower processing of information, decreased power and influence over their own lives, withdrawal from work and separation from family and friends. On the other hand, older patients are more likely to accept medical authority, both in terms of attitudes and behaviour, than younger groups [45].

Doctor-Patient Relationship with Patients and Special Situations

Patients and situations such as emigrants, foreigners, patient with ill-defined symptoms, the psychotic, with the patient with visual or hearing impairment, at home, with differences of race, social class, gender, etc. can be included here [46,47].

Conclusion

The doctor-patient relationship has been and remains a keystone of care. The desirable model of doctor-patient interaction has been the subject of controversy and debate in recent years without ever reaching an adequate degree of consensus on how to define and even name it. This article intends an approximation to its systematization.

There are many ways to understand, classify and practice the doctor-patient relationship. They are types and forms that overlap and have translations from one system or classification model to another. So we have: 1) Hierarchy of complexity dimensions of the doctor-patient continuity relationship (Informative relationship, Geographic relationship, Interdisciplinary or team continuity relationship, Longitudinal or chronological relationship, Doctor-patient interpersonal relationship, and Doctor-family interpersonal relationship); 2) According to historical stages (magical, mystic, etc.); 3) According to the degree of interpersonal relationship (technical or psychotherapeutic interpersonal model); 4) According to the control exercised by the physician or the patient (paternalistic, consumerist, mutual relationship, and absent relationship); 5) According to types of doctor-patient relationship according to the level of participation ("Active-passive" relationship, "Guided cooperation" relationship, and "Mutual participation" relationship); 6) According to models of relationship "creators of context" (Unidirectional information strategy, Persuasive or consultative strategy, and Participatory-cooperative strategy with empowerment); 7) Types of doctor-patient relationship in relation to the duration of interpersonal continuity; 8) Medical-patient pharmacological relationship; 9) Types of patient physician relationship according to the characteristics of the medical service (doctor-patient relationship in general medicine, gynecology, surgery, in dermatology, in intensive care, etc.); 10) According to the psychosocial aspects of diseases (relationship doctor with cardiovascular patient, doctor-hypertensive patient, asthmatic patient, digestive patient, patient in psychiatric diseases, in digestive, endocrinological problems, with an incurable disease, with hematological diseases, with cancer, or the doctor-patient relationship with AIDS, among others; 11) Doctor-patient

relationship according to age; and 12) Doctor-patient relationship with patients and special situations: emigrants, foreigners, patient with ill-defined symptoms, with the insane, with the psychotic, with the patient with visual or hearing impairment, at home, with differences of race, social class, gender, etc.).

A serious problem of the models is that it does not know the "active ingredients" of each one. On the other hand, the medical interview cannot be understood as a single encounter. The doctor and the patient develop continuous friendly relations, which have historical precedents and expectations of continuity. Most of the research on medical interview has been done, however, on visits of new problems rather than on the follow-up of known problems. Nor is there much research on the effect of the organization of health systems on the doctor-patient relationship, which is probably a crucial factor.

It is concluded that the doctor-patient relationship is a complex, multiple and heterogeneous concept that cannot be defined in a unique way or generalize the concept of "good" relationship, but there are "many doctor-patient relationships" appropriate according to different contexts and criteria, which also implies redefining the instruments for measuring this relationship.

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